ARIZONA LOAN REPAYMENT PROGRAM
PRIMARY CARE PROVIDER APPLICATION

Mail completed *Provider* and *Service Site Applications* to:

Arizona Department of Health Services
Office of Health Systems Development
Attn: Loan Repayment Program Manager
1740 W. Adams Street, Room 410
Phoenix, Arizona 85007

Direct all inquiries to:
PH: 602-542-1219
FX: 602-542-2011
vallef@azdhs.gov or
jamest@azdhs.gov

****Be sure to include copies of requested additional information****

Date submitted_____ Date received_____

ARIZONA LOAN REPAYMENT PROGRAM (LRP)
SERVICE SITE APPLICATION

*(Complete the information below for the service site at which the LRP provider/applicant will be working)**

1. Name of service site: _____

   Site Address: _____

   _____
   (City) (County) (Zip Code)

2. Employer Information
   Name of Organization: _____
   Executive director/manager's name: _____
   Mailing Address: _____

   _____
   (City) (Zip Code) (Phone)

   Is Employer a non-profit organization? Yes _____ No _____

3. Does this site accept Title XVIII (Medicare), Title XIX (Medicaid/AHCCCS) and Title XXI (SCHIP/KidsCare)? Yes _____ No _____

   If yes, provide Medicare identification number _____
   AHCCCS provider number _____

4. Distance from this site to the nearest city or town with a population of 20,000 or more _____

5. Name of the federally designated Health Professional Shortage Area (HPSA) and the Federal identification number, if known, in which the service site is located:

   _____

6. **Assurances of Service Site Eligibility (for executive director/manager's initials):**

   _____ A. This site is in compliance with the LRP site eligibility requirements.

   To be eligible to have a primary care provider participate in the PCPLRP, a service site shall:
   1. Provide primary care services in a public or nonprofit private practice located in a HPSA;
   2. Accept Medicare, Medicaid (AHCCCS) and KidsCare assignment;
   3. Charge for services at the usual and customary rates prevailing in the primary care area, except that the service site shall have a policy providing that patients unable to pay the usual and customary rates shall be charged a reduced rate according to the service site's sliding-fee scale based on federal poverty level guidelines; and
   4. Not discriminate on the basis of a patient's ability to pay for care or the payment source, including Medicare or AHCCCS.

_____ B. This site has an employment contract for this provider to cover the period of loan repayment applied for, and has the financial means available to support the primary care provider, including salary, benefits, and malpractice insurance expenses for a minimum of 24 months.

_____C. This site has a sliding fee scale in place for patients without health insurance based on current year poverty levels as dictated by the Federal Register.
(Attach a copy of the sliding fee scale and the office procedure for its use.)

_____ D. The primary care provider awarded loan repayment funds will work full-time (minimum of 40 hours) in their profession at this site.

*Unless an obstetrician or nurse midwife, LRP providers must work a t least 32 of the minimum 40 hours per week providing ambulatory care services at the approved service site during scheduled office hours. If an obstetrician or nurse midwife, LRP providers must work a t least 21 of the minimum 40 hours per week providing ambulatory care services at the approved service site during scheduled office hours.

I hereby certify that, to the best of my knowledge, the information contained in this application is accurate, and hereby authorize the Arizona Department of Health Services or its designee to verify all information presented.

Typed or Printed Name of executive director/manager: _____

Signature of executive director/manager: _____ Date: _____
State of)
County of)
The foregoing instrument was acknowledged before me this _____ day of _____ .

_____ My Commission Expires: _____
Notary Public

WARNING: *Any person who knowingly makes a false statement or misrepresentation or material omission in this loan repayment application, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment. I have read this statement and understand its contents.*

_____
(initials of executive director/manager)

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Forward this form along with the Primary Care Provider Application to the Arizona Loan Repayment Program Manager at the address listed on the front of the application.

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